



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 2/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute includes the medical necessity of a chronic pain management program x 10.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Psychiatry. This reviewer has been practicing for greater than 15 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the medical necessity of a chronic pain management program x 10.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): xxxx: 12/23/09 denial letter, 1/6/10 denial letter, 12/18/09 preauth request, 12/16/09 preauth request letter, 12/29/09 preauth request, 12/28/09 appeal for services letter and 8/14/09 MRI of the left shoulder report.

FPC: 10/29/09 mental health assessment report.

Dr.: 1/19/10 DWC 69 and report, various DWC 73 forms, 12/2/09 report by MD, 12/16/09 to 12/18/09 reports by MD, 10/29/09 report by MD, office notes by PA-

C 8/31/09 to 10/1/09, notes by PA-C 6/24/09 to 1/26/10, 12/28/09 appeal for preauth, 10/28/09 eval interim report, 7/28/09 initial eval report, PT note undated from PT, 9/3/09 to 9/18/09 treatment summaries

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a woman, who was injured on xx/xx/xx when boxes fell on her shoulder, neck, and upper back at her job as a cook. She was treated with various therapies and medications including an antidepressant. Her diagnosis was pain disorder and adjustment disorder with anxiety and depression. She had been employed for 5 months. At the time of the assessment on 12/16/2009 by the pain program doctors, she was back at work three days per week. Her job performance was impeded by her injury.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The requested treatment was for 2 weeks of treatment in an outpatient multidisciplinary pain program. The ODG defines a multidisciplinary pain program as treatment provided by a team of doctors, counselors, and therapists providing psychological and behavioral care, physical treatment, medical care and supervision, vocational rehabilitation, education, and psychosocial care. Complete evaluations in these areas including a physical exam are required prior to the treatment in the pain program. Documentation in all of these areas was lacking. No documentation was found for the various evaluations or from the various disciplines. Letters from Dr. for the pain program referred to assessment and therapies, but no other documentation was provided. The ODG requirements of a multidisciplinary pain program were not met; therefore, the requested service is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)